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NOT TO BE PUBLISHED IN OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

DIVISION TWO

JORDAN ROSENBERG, Plaintiff and Appellant, v. HEALTH NET, INC., Defendant and Respondent.	A131756 (San Francisco County Super. Ct. No. CGC-10-500277)

I. INTRODUCTION

The Medicare Act, a part of the Social Security Act, established a federally-subsidized health insurance program for older and disabled Americans. (42 U.S.C. § 1395 et seq.; *McCall v. PacifiCare of California, Inc*. (2001) 25 Cal.4th 412, 416 (*McCall*).) The program is divided into "Parts." The present case involves Medicare Part D, a voluntary prescription drug benefit program for seniors. (42 U.S.C. § 1395w-101, et seq.) "Under the Act, health insurance providers contract with the Center for Medicare Services ('CMS'), part of the Department of Health and Human Services, to offer Part D prescription drug plans ('PDPs') to Medicare beneficiaries." (*Uhm v. Humana, Inc*. (2010) 620 F.3d 1134, 1138 (*Uhm*).)

Jordan Rosenberg (Rosenberg) filed a complaint against Health Net, Inc. (Health Net) seeking restitution, damages and other equitable relief for his allegedly wrongful disenrollment from Health Net's Medicare Part D prescription drug plan. The trial court sustained demurrers to the entire complaint, finding that some of Rosenberg's claims

were subject to administrative exhaustion and that others were preempted by the Medicare Act. We affirm.

II. STATEMENT OF FACTS

A. *Rosenberg's Complaint*

On October 29, 2010, Rosenberg filed a complaint which sets forth the following core factual allegations: "Plaintiff Rosenberg was a customer of Healthnet, Inc, an insurer providing Rosenberg with insurance coverage under Medicare Part D, the prescription drug coverage. During the month of May 2007 defendants canceled [sic] Rosenberg's coverage without good reason and refused to re-instate it despite Rosenberg's repeated demands that they do so. As a result Rosenberg was without coverage, was without the means to obtain needed continuing medications, and was at risk for damage to his health and had his health damaged. In June, Rosenberg was able to find alternative coverage but no alternative coverage was possible under Medicare rules for May."

In his first cause of action, Rosenberg alleged Health Net is liable to him for fraud. In addition to the facts quoted above, Rosenberg alleged that Health Net made the following misrepresentations to him via its website or other promotional literature: (1) Health Net's insurance would enable Rosenberg to purchase medicines; (2) Health Net has a customer service department that is willing and able to help with problems; and (3) customers may contact Health Net by e-mail.

Relying on the same allegations used to support his fraud cause of action, Rosenberg also alleged or attempted to allege additional claims for violation of the state Consumer Legal Remedies Act (CLRA), Civil Code section 1770 et seq. (second cause of action), violation of the state unfair competition law (UCL), Business and Professions Code section 17200 et seq. (third cause of action), and intentional infliction of emotional distress (fourth cause of action).

Finally, in both his fifth and sixth causes of action, Rosenberg alleged that Health Net is liable to him for negligence.[1] Rosenberg alleged that Health Net assumed a duty to him which it breached by canceling his insurance without cause and by refusing to restore his insurance coverage and, as a result, he was "denied his medications and so damaged."

B. *The Demurrers*

On November 10, 2010, Health Net filed demurrers to Rosenberg's entire complaint in which it argued that Rosenberg failed to exhaust his administrative remedies, that all of Rosenberg's claims are preempted by the Medicare Act, and that Rosenberg failed to state a cause of action under the CLRA, the UCL, or for negligence.

On January 12, 2011, a hearing on the demurrers was conducted before the Honorable Peter J. Busch. Rosenberg, who has represented himself throughout this case, has elected to omit the transcript of that hearing from the record on appeal.

On February 9, 2011, the court filed an order sustaining demurrers to all of Rosenberg's causes of action without leave to amend. The court found that Rosenberg's two negligence claims arise under the Medicare Act and Rosenberg was required to but failed to exhaust his administrative remedies. The court also found that Rosenberg's remaining causes of action are preempted by federal law.

III. DISCUSSION

A. *Standard of Review*

"A demurrer tests the legal sufficiency of the factual allegations in a complaint. We independently review the sustaining of a demurrer and determine de novo whether the complaint alleges facts sufficient to state a cause of action or discloses a complete defense. [Citation.] We assume the truth of the properly pleaded factual allegations, facts that reasonably can be inferred from those expressly pleaded, and matters of which judicial notice has been taken. [Citation.] We construe the pleading in a reasonable

[1] We will ignore the seventh cause of action in the complaint which is for "respondeat superior" because that is not a distinct legal claim.

manner and read the allegations in context. [Citation.] We must affirm the judgment if the sustaining of a general demurrer was proper on any of the grounds stated in the demurrer, regardless of the trial court's stated reasons. [Citation.]" (*Vitkievicz v. Valverde* (2012) 202 Cal.App.4th 1306, 1310-1311.)

B. *The Negligence Claims*

The trial court sustained demurrers to Rosenberg's fifth and sixth causes of action for negligence on the ground that these claims are subject to the administrative exhaustion provisions of the Medicare Act and that Rosenberg failed to exhaust his administrative remedies.

The Medicare Act establishes an administrative scheme for determining entitlement to benefits under the Act which is administered by the Commissioner of Social Security. (42 U.S.C. § 405.) That process establishes the " 'sole avenue' " for judicial review for all claims " 'arising under' " the Medicare Act. (*Heckler v. Ringer* (1984) 466 U.S. 602, 614-615; see also *Kaiser v. Blue Cross of California* (9th Cir. 2003) 347 F.3d 1107, 1111 ["Jurisdiction over cases 'arising under' Medicare exists only under 42 U.S.C. § 405(g), which requires an agency decision in advance of judicial review."].) "Judicial review of a claim for benefits is available only after the [Commissioner] has rendered a ' "final decision" ' on the claim, and only in the manner provided for claims for old age and disability benefits arising under the Social Security Act." (*McCall, supra*, 25 Cal.4th at pp. 416-417, quoting *Heckler, supra*, 466 U.S. at p. 605.)

A claim " 'arises under' " the Medicare Act and therefore requires exhaustion when (1) the " 'standing and the substantive basis for the presentation' " of the claim is the Medicare Act, or (2) the claim is " 'inextricably intertwined' " with a claim for Medicare benefits. (*Heckler, supra*, 466 U.S. at pp. 614-615.) Cases applying this test establish that the remedy sought by a complaint is not determinative. The claim may still arise under the Act even if the complaint does not seek payment or reimbursement of a Medicare claim or benefit. (*McCall, supra*, 25 Cal.4th at pp. 417-418.) Thus, for example, " ' "[c]leverly concealed claims for benefits" ' " are subject to exhaustion. (*Uhm, supra*, 620 F.3d at p. 1141.) On the other hand, "a claim that is 'wholly

"collateral" ' to a claim for benefits under the Act is not subject to the administrative process . . . ." (*McCall, supra*, 25 Cal.4th at p. 417.)

Applying these rules to the present case, we affirm the trial court's finding that Rosenberg's fifth and sixth causes of action for negligence arise under the Medicare Act. Rosenberg has alleged that Health Net had a duty to him which it breached by cancelling and refusing to restore his Medicare Part D insurance "without cause," and that this alleged breach of duty harmed Rosenberg by depriving him of his medication. In other words, Rosenberg is claiming that he was entitled to benefits under Medicare Part D and that Health Net wrongfully deprived him of those benefits by terminating and then refusing to reinstate his coverage.

The substantive basis for this claim, and Rosenberg's standing to bring it, is the Medicare Act itself which provides that the "Secretary shall establish a process for the enrollment, disenrollment, termination, and change of enrollment of part D eligible individuals in prescription drug plans . . . ." (42 U.S.C. § 1395w-101(b).) Pursuant to this statutory directive, the CMS has established a regulatory scheme governing eligibility and enrollment in Part D plans which includes, among other things, rules for "Involuntary disenrollment from Part D coverage." (42 C.F.R. § 423.44.)

By the same token, Rosenberg's negligence causes of action are inextricably intertwined with a claim for benefits under the Act. Rosenberg's allegations that Health Net breached its duty by terminating his coverage without cause necessarily and directly implicate the process for disenrollment established by the Act. Furthermore, the denial of a Medicare benefit is the only harm that Rosenberg allegedly suffered as a result of the claimed breach of duty.

Rosenberg contends that none of his claims arise under the Medicare Act because his complaint does not seek the payment of any Medicare benefits. As a factual matter, we cannot determine whether Rosenberg seeks payment for or reimbursement of an actual claim for benefits because his prayer for relief is so general and so broad (e.g., "[c]ombined monetary relief not more than $10,000,000.00"). We do note, however, that the first item of relief listed in the prayer of the complaint is a request for restitution.

In any event, as explained above, the fact that a plaintiff does not expressly seek the payment of a Medicare benefit is not dispositive. Rather, the test is whether the Medicare Act establishes the substantive basis for the claim and the standing to assert it or whether the claim is inextricably intertwined with a claim for Medicare benefits. (*McCall, supra*, 25 Cal.4th at pp. 417-418.) Here, both prongs of this test apply to the negligence claims. Health Net's duty to Rosenberg with respect to the cancellation and/or restoration of his Medicare Part D prescription drug benefits arose from the Medicare Act itself. Furthermore, the only harm resulting from Heath Net's alleged breach of its duty was the deprivation of a benefit that is also created by the Medicare Act.

Rosenberg also argues that his complaint does not arise under the Medicare Act because he alleged that his enrollment in the Part D plan "was secured by fraud" and, if he proves his fraud allegations, then he was never "legally" enrolled as a member of a Part D plan and he is not a person "covered" by Medicare's exhaustion provision. Rosenberg fails to cite any authority for this illogical proposition. On this record, Rosenberg's enrollment in a Medicare Part D program is an essential premise of his negligence claims; Rosenberg's theory of negligence is that Health Net owed him a duty not to cancel his Medicare benefits.

Arguably, Rosenberg's fraud based claims do not arise under the Medicare Act. At least to the extent that Rosenberg seeks a remedy for Health Net's alleged misrepresentations, his claim could be construed as collateral to any claim for benefits afforded by the Act. (See *Uhm, supra*, 620 F.3d at p. 1145.) However, the trial court did not find that Rosenberg's fraud and consumer protection law claims arise under the Medicare Act or that they are subject to administrative exhaustion. Rather, the trial court found that the exhaustion requirement applies to the two negligence claims.

In his reply brief, Rosenberg argues that when he "points out he was denied benefits he is describing the harm done, not the remedy sought. Rosenberg was denied coverage, hence he didn't get his drugs for a month, and his health suffered." Although this reasoning is confusing, it appears that Rosenberg is conceding that the only harm he

suffered as a result of the alleged breach of Health Net's duty was that he was denied Medicare benefits. Thus, to obtain damages for this harm, Rosenberg would have to show that he was entitled to benefits in the first place and such an inquiry is inextricably intertwined with a claim for Medicare benefits.

Rosenberg mistakenly relies on *McCall, supra*, 25 Cal.4th 412. *McCall* holds that a state-law-based claim by a Medicare beneficiary is not subject to the administrative review process if the claim is "collateral to, not inextricably intertwined with" a Medicare benefit claim. (*Id*. at p. 425.) If the plaintiff can prove the elements of his cause of action "without regard, or only incidentally, to Medicare coverage determinations," that claim is not subject to the administrative exhaustion requirement. (*Id*. at p. 426.) As discussed above, Rosenberg cannot prove his negligence claims without directly establishing that he was wrongfully denied Medicare benefits. Thus, the trial court properly granted Health Net's demurrer as to those causes of action.

C. *The Remaining Claims*

The trial court sustained demurrers to the causes of action that are not based on negligence because it found those claims are preempted by the Medicare Act. "The Supreme Court has made clear that Congress may displace state law through express preemption provisions. [Citation.]" (*Uhm, supra*, 620 F.3d at p. 1148.) Medicare Part C, "the Medicare Advantage ('MA') program, which provides medical benefits to seniors through managed care" contains an express preemption provision. (*Ibid*.)

The Part C preemption states: "The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part." (42 U.S.C. § 1395w-26(b)(3).)[2]

[2] This preemption provision was enacted in 2003 as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. "The prior preemption provision was more narrow, though still fairly broad[.]" (*Phillips v. Kaiser Foundation Health Plan, Inc.* (2011) 2011 U.S. Dist. LEXIS 80456 p. 21, fn. 10 (*Phillips*).)

The Part C preemption provision is expressly incorporated into Medicare Part D. (42 U.S.C. § 1395w-112(g) ["The provisions of sections 1395w-24(g) and 1395w-26(b)(3) shall apply with respect to PDP sponsors and prescription drug plans under this part [42 U.S.C. §§ 1395w-101 et seq.] in the same manner as such sections apply to MA organizations and MA plans under part C [42 U.S.C. §§ 1395w-21 et seq.]."].)[3] "The plain language of the statute therefore provides that CMS 'standards' supersede 'any State law or regulation . . . with respect to' a 'prescription drug plan' offered by a 'PDP sponsor.'" (*Uhm, supra*, 620 F.3d at p. 1148-1149.)

Pursuant to its authority under Medicare Part D, the CMS has promulgated extensive regulations governing the marketing of Part D prescription drug benefits to Medicare beneficiaries. (*Uhm, supra*, 620 F.3d at pp. 1150-1157; see also *Phillips, supra,* 2011 U.S. Dist. LEXIS 80456, pp. 28-29.) Under this regulatory scheme, the CMS must review and approve all marketing materials targeted at Medicare beneficiaries to ensure compliance with extensive statutory guidelines. (42 C.F.R. § 422.2262; 42 C.F.R. § 422.2264.) The CMS also regulates the marketing activities of MA organizations and imposes licensing requirements on employees and marketing representatives employed by those organizations. (42 C.F.R. § 422.2268; 42 C.F.R. § 422.2272.)

The broad reach of this regulatory scheme is reflected in its definition of "marketing materials" which includes, but is not limited to: "(i) General audience materials such as general circulation brochures, newspapers, magazines, television, radio, billboards, yellow pages, or the Internet. [¶] (ii) Marketing representative materials such as scripts or outlines for telemarketing or other presentations. [¶] (iii) Presentation materials such as slides and charts. [¶] (iv) Promotional materials such as brochures or

[3] This preemption provision is also incorporated into the language of the Part D implementing regulation. 42 C.F.R. § 423.440(a) states, in part: "The standards established under this part supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) for Part D plans offered by Part D plan sponsors."

leaflets, including materials for circulation by third parties (for example, physicians or other providers). [¶] (v) Membership communication materials such as membership rules, subscriber agreements, member handbooks and wallet card instructions to enrollees. [¶] (vi) Letters to members about contractual changes; changes in providers, premiums, benefits, plan procedures etc. [¶] (vii) Membership activities (for example, materials on rules involving non-payment of premiums, confirmation of enrollment or disenrollment, or nonclaim specific notification information)." (42 C.F.R. § 422.2260(5).[4])

A crucial function of the Part D preemption provision is to avoid application of a state law that "could potentially undermine the Act's standards as to what constitutes non-misleading marketing." (*Uhm, supra,* 620 F.3d at p. 1152; see also *Phillips, supra,*

[4] This regulation states: "Marketing materials include any informational materials targeted to Medicare beneficiaries which: [¶] (1) Promote the MA organization, or any MA plan offered by the MA organization. [¶] (2) Inform Medicare beneficiaries that they may enroll, or remain enrolled in, an MA plan offered by the MA organization. [¶] (3) Explain the benefits of enrollment in an MA plan, or rules that apply to enrollees. [¶] (4) Explain how Medicare services are covered under an MA plan, including conditions that apply to such coverage. [¶] (5) May include, but are not limited to, the following: [¶] (i) General audience materials such as general circulation brochures, newspapers, magazines, television, radio, billboards, yellow pages, or the Internet [¶] (ii) Marketing representative materials such as scripts or outlines for telemarketing or other presentations. [¶] (iii) Presentation materials such as slides and charts. [¶] (iv) Promotional materials such as brochures or leaflets, including materials for circulation by third parties (for example, physicians or other providers). [¶] (v) Membership communication materials such as membership rules, subscriber agreements, member handbooks and wallet card instructions to enrollees. [¶] (vi) Letters to members about contractual changes; changes in providers, premiums, benefits, plan procedures etc. [¶] (vii) Membership activities (for example, materials on rules involving non-payment of premiums, confirmation of enrollment or disenrollment, or nonclaim specific notification information). [¶] (6) Marketing materials exclude ad hoc enrollee communications materials, meaning informational materials that-- (i) Are targeted to current enrollees; [¶] (ii) Are customized or limited to a subset of enrollees or apply to a specific situation; [¶] (iii) Do not include information about the plan's benefit structure; and [¶] (iv) Apply to a specific situation or cover claims processing or other operational issues. (42 C.F.R. § 422.2260.)

2011 U.S. Dist LEXIS 80456 at p. 28-29.) In the present case, Rosenberg's fraud and consumer protection law claims clearly pose this threat.

These claims all rest on the premise that Health Net made misleading representations regarding the nature of its Plan D coverage. Rosenberg alleged that the alleged representations were made on Health Net's "web site or the Medicare web site or in promotional literature as part of [Health Net's] marketing program to get him [to] buy his insurance from them." These alleged representations, which are at the heart of Rosenberg's non-negligence claims, constitute marketing materials under the Medicare Act and are expressly regulated by the CMS. Thus Rosenberg's state law claims for fraud and consumer protection law violations are preempted by the Medicare Act. (*Uhm, supra,* 620 F.3d at p. 1152; *Phillips, supra,* 2011 U.S. Dist LEXIS 80456 at pp. 28-29)

On appeal, Rosenberg concedes that "Medicare does indeed have a regulation that says it is to review and approve 'marketing materials' before they may be used," and that the "regulation details a long list of what " 'marketing materials' means." Rosenberg contends, however, that this regulation is irrelevant unless and until Health Net proves that the CMS actually reviewed the marketing materials that Rosenberg targets in his complaint. Again, Rosenberg provides no authority for this novel contention which strikes us as patently erroneous. The validity of an express preemption provision cannot hinge on whether the agency at issue did its job in a particular factual situation because making that inquiry would invade the very province that Congress has removed from state control.

IV. DISPOSITION

The judgment is affirmed.

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Haerle, Acting P.J.

We concur:

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Lambden, J.

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Richman, J.